Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

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Caregiver's Patient Limit Waiver

Patients may petition the Registry for permission to increase the number of people their caregiver can serve. The patient and caregiver must be able to clearly explain how granting an extension to the caregiver will benefit the patient's health, safety and welfare. The caregiver must be providing services beyond growing and/or transporting medical marijuana for the patient.

Instructions:

1. **Do not submit this form by itself.** It must be submitted by the patient with either a patient application packet (MMR1001 or MMR1002) or a Change of Patient Records form (MMR1003).
2. Complete this form if your caregiver is currently serving **five (5) or more** patients. Complete all sections of the form neatly and accurately.
3. **There are no fees to file this form.**
4. **Do not write-over, cross-out, or use white-out on this form, or it will be voided**. If you make a mistake on the form, please complete a new one.
5. Submit the application to the Registry within **ten (10) days** of the date you have it notarized.
6. If approved, the term of the waiver will be one year.
7. If the caregiver's caseload drops to five (5) or fewer patients, **the waiver is terminated**.
8. After completion, the patient and caregiver must both sign and date it in front of a notary to have it notarized.
9. **Include a copy of the patient's and caregiver's valid photo IDs.** The chart below lists the documents the Registry accepts as proof of identity.

PROOF OF IDENTITY	
The Registry requires a verifiable, photo ID for all forms. Please submit one of the following IDs with your form:	
• Colorado Driver's License • Colorado photo ID • Temporary Colorado Driver's License • Temporary Colorado ID	• Out-of-state Driver's License • Out-of-state photo ID • U.S. Passport • Military ID (copy of front and back) • Tribal ID
i. All documents must be currently valid when received at the Registry. ii. Damaged, expired, or tampered IDs are not valid. iii. The address on the photo ID **does not** have to match the mailing address on the form. iv. All IDs must be verifiable and have specific issue and expiration dates. v. The ID must show the patient's date of birth.	

10. Patient social security numbers are used to confirm identity and protect confidentiality.
11. Incomplete forms will be rejected. A form is considered complete when:
    a. The form is completed, signed and notarized.
    b. A copy of the patient's photo ID is included.
    c. A copy of the caregiver's ID is included, if the form has caregiver information.
12. Forms must be sent separately, one form per envelope.
13. Make a copy of all your paperwork for your files.
14. Unless a fee is required, DO NOT send money to the Registry. All monies received at the Registry are nonrefundable.
15. Submit paperwork by mail or deliver to the Registry's drop-box. The Registry does not accept forms by fax or e-mail.

Mail to:

Customer Service Unit
Colorado Dept. of Public Health & Environment
HSV-MMR
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, South East Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

For more information, visit our website www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.

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STAFF ONLY

Review Committee Approval
❑ **Yes** ❑ **No**

Corrections:

Caregiver's Patient Limit Waiver

See instructions on page 1. Photo ID required with all forms.

1. Social Security Number (optional) - -	**Section A: Patient Information** **The name on the form must match the legal name on your photo ID.**			
2. Last Name	3. First Name		4. Middle Initial	
5a. Mailing Address	5b. Apartment/Suite #	6. City		
State **CO**	7. Zip Code	8. County	9. Date of Birth - -	10. Telephone Number ( ) -
11. E-mail Address (optional)*			12. Gender ☐ Male ☐ Female	

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

Section B: Caregiver Information

A copy of the caregiver's photo ID is required. The name on the form must match the legal name on the caregiver's ID.

13. Caregiver's Last Name (as on ID)	14. Caregiver's First Name (as on ID)		15. Middle Initial
16. Caregiver's Mailing Address		16a. Apartment/Suite #	
17. City	18. State	19. Zip Code	20. Date of Birth - -	21. Telephone Number ( ) -

Section C: Medical Marijuana Center Information

22: Is there a Medical Marijuana Center within five (5) miles of the patient's address? ☐ **Yes** ☐ **No**
If yes, complete the following information.

23. Name of Medical Marijuana Center			
24. Mailing Address of the Medical Marijuana Center		24a. Apartment/Suite #	
25. City	State **CO**	26. Zip Code	27. Telephone Number ( ) -

28. How will granting this waiver benefit the patient's health, safety and welfare?

29. What services, beyond providing medical marijuana, does the patient require for the caregiver?

Colorado Department of Public Health and Environment

Caregiver's Patient Limit Waiver

Patient's Name: _____ **Patient's Social Security Number:** ____-____-____

STAFF ONLY

Review Committee Approval
❑ **Yes** ❑ **No**

Corrections:

30. Patient's Signature: Please check (✓) the box below, to consent to requested changes.

By signing below, I request that the above-mentioned caregiver be granted permission to serve more than five patients. If the caregiver is granted a waiver, I request this caregiver be listed as my primary caregiver.

I hereby certify that the above information is correct and complete.	
31. Patient's Signature: ▶	32. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of patient printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL

33. Caregiver's Signature: Please check (✓) the box below, to consent to the requested changes.

I believe increasing the number of patients I can serve will benefit the patient's health, safety and welfare. By signing below, I consent to assuming significant responsibility for managing the patient's well-being.

I hereby certify that the above information is correct and complete.	
34.Caregiver's Signature: ▶	35. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County,
(Name of caregiver printed by notary) (County name)

Colorado on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL